TUBERCULOSIS CLINIC PATIENT RECORD

TO:_____ D.O.B. _____

TB skin test reading or verified history:

X-ray results:

Preventive therapy: Yes ____ No ____ If no, reason: _____

Therapy completed: _____

Active case: Treated from _____ to _____.

Sputums negative since: _____. Therapy completed: _____

If the following symptoms should occur, please contact your private physician or the county health department:

1. productive cough 2. bloody sputum 3. night sweats

4. loss of appetite 5. unusual tiredness 6. weight loss

7. low-grade fever

The above client should <u>not</u> receive another TB skin test for the remainder of their lifetime, and only needs a repeat chest x-ray if having any of the above symptoms.

Any County Health Department
Any Street
Anywhere, Kansas 00000
(000) 000-0000